ABSTRACT

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AN EXPLORATORY STUDY OF THE RELATIONSHIP BETWEEN A PATIENT'S EDUCATIONAL LEVEL AND THE COMPLETION OF ADVANCE DIRECTIVES

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The overall objective of this study was to determine if there is a relationship between a patient's educational level and the completion of advance directives. To obtain this objective, the following areas were addressed by the researcher: (a) issues related to the education of patients (b) issues related to the completion of advance directives. The population consisted of 50 patients, male and female, ages ranging from twenty-five years to seventy-six plus years admitted to an acute care setting. Findings of the study indicate there is no significant relationship between a patient's educational level and the completion of advance directives.

AN EXPLORATORY STUDY OF THE RELATIONSHIP BETWEEN A PATIENT'S EDUCATIONAL LEVEL AND THE COMPLETION OF ADVANCE DIRECTIVES

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CHAPTER ONE

INTRODUCTION

Dying in America is no longer simply to stop breathing or for one's heart to stop beating. The times of people dying in their homes have been replaced with their final days, months and even years spent in hospitals or nursing homes attached to pumping, buzzing, sophisticated machinery.[1]

In a fifty year span the increase in deaths in institutions has risen drastically.[2] In 1939, only 37 percent of the United States population died in an institution.[3] In comparison, Danforth's report indicated that in 1989, 80-85 percent of deaths occurred in hospitals and medical centers. Approximately 80 percent of the deaths in institutions required a decision to apply, withhold or withdraw medical treatment.[4] The simplicity of dying was lost in the late 1950's with the introduction of cardiopulmonary resuscitation

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[1] Begley, S. and Starr, M. (1991). Last Rights: In Sickness and in Health, More People are taking Life's Biggest Decision Away From Doctors and Into Their Own Hands. Newsweek. August. 40-46.

[2]Danforth, J. Sen. Missouri. (1991). Statements on Introduced Bills and Joint Resolutions. Congressional Record S13555. 135, no. 140.

[3]Ibid.

[4]Levin, S.M. Rep. Michigan. (1990). Patient Self-Determination Act of 1990. Congressional Record D943. 136, No. 39.

or CPR.[5] Hospital embraced this new technological advancement of saving lives and made CPR a standing order for all patients suffering from cardiopulmonary distress.[6] Nearly ten years of the hospital's standing order of CPR had passed and the doctrine of informed consent evolved.[7] With this evolution hospitals began instituting criteria for "Do Not Resuscitate" to modify the standard policy of maintaining life with the use of CPR.[8] By 1969, Luis Kutner, an attorney in the state of Illinois, introduced the first living will giving way to the belief that every person has he right to self-determination.[9]

The 1970's produced added healthcare technology which resulted in saving more lives, and also increased the ethical dilemmas concerning self-determination. By 1976, this growing public issue of a living will began receiving more recognition, and the state of California enacted the first

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[5]U.S. Congress, Office of Technology Assessment, Institutional Protocols for Decisions About Life - Sustaining Treatments, Special Report OTA-BA-389, Washington, D.C.: U.S. Government Printing Office, 1987).

[6]Ibid.

[7] Ibid.

[8]Hassmiller, S. (1991). Bringing the Patient Self-Determination Act Into Practice. Nursing Management. 22, 29-32.

[9]Nanovic, S.J. (1990). "The Living Will: Preservation of the Right to Die Demands Clarity and Consistency." Dickinson Law Review, 95: 1: 109-234.

Natural Death Act.[10]

Over the next decade courts would hear cases (i.e. Quinlan vs. New Jersey Supreme Court, Cruzan vs. Missouri Supreme Court) from various families requesting that their loved ones being kept alive by the use of artificial respiration, hydration, and nutrition be removed from such machinery and allowed to die.[11] The courts decision to allow Quinlan's father to exercise her right to refuse medical treatment established a legal precedent in proxy decision making and introduced the concept of a "right to die".[12] By 1983, the state of California became the first to enact legislation recognizing a durable power of attorney specifically for health care decisions.[13] On December 6, 1989, the first "right to die" case was heard by the United States Supreme Court.[14] The court decided that according to the Fourteenth Amendment: "The principle that a competent person has a constitutionally protected liberty interest in refusing

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[10]Hassmiller, S. (1991). Bringing the Patient Self-Determination Act Into Practice. Nursing Management. 22, 29-32.

[11]Ibid.

[12]Emanuel, E.J., and Emanuel, L.L. (1992). Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis. JAMA. Vol 267, No. 15, 2067-2071.

[13]Steinbrook, B.R. and Lo, B. (1984). Decision-Making for Incompetent Patients by Designated Proxy: California's New Law. New England Journal of Medicine. 310: 1598-1601.

[14]Hassmiller, S. (1991). Bringing the Patient Self-Determination Act Into Practice. Nursing Management. 22, 29-32.

unwanted medical treatment may be inferred from our prior decisions."[15] This decision gave added weight and value to the possibility of legalizing advanced directives.[16]

This issue of advanced directives continued to gain momentum and was a topic of concern to government officials, health and social welfare agencies, policymakers and the general public. In 1990, Senator John Danforth of Missouri introduced the Patient Self-Determination Act (PSDA) as part of Omnibus Reconciliation Act of 1990.[17] By December 1991, the Patient Self-Determination Act was passed.[18] This law mandates that all hospitals, nursing facilities, home health agencies, and hospice programs that receive federal reimbursement to provide upon admission, adult patients with written information regarding patients' rights, including the right to make decisions about medical care at the end of their lives, the right to make a living will and the right to assign durable power of attorney.[19] Secondly, this law requires documentation in the persons' medical record whether or not the individual

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[15]Cruzan vs. Director, Missouri Department of Health (1990) 110 S. Ct. 2851.

[16]Hassmiller, S. (1991). Bringing the Patient Self-Determination Act Into Practice. Nursing Management. 22, 29-32.

[17]Ibid.

[18]Ibid.

[19]Barriers to Completion of Living Wills. (1992). American Family Physician. Vol. 46, p. 1528.

has executed and advance directive.[20] Thirdly, the law requires the healthcare agency to avoid discrimination on the basis of whether or not an advance directive has been executed.[21] Lastly, this law mandates that agencies provide staff and community education on issues concerning advance directives.[22] Once discussed with each patient the healthcare agency is responsible for providing any additional information requested by the patient.[23]

Advanced directives are documents that allow individual patients to direct in advance how they want to be treated should an illness or accident incapacitate them later on.[24] Most often advanced directives are one of two types. The first, a healthcare proxy allows people to appoint a specific individual such as, a healthcare agent to make healthcare decisions for them should they become unable to speak for themselves.[25] The second type of an advanced directive is a living will. A living will is a document in which you can

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[20] Hassmiller, S. (1991). Bringing the Patient Self-Determination Act Into Practice. Nursing Management. 22, 29-32.

[21] Ibid.

[22] Ibid.

[23] Ibid.

[24] The American Nurse. (1992). Nurses to Educate For End-of-Life Decisions: What is an Advanced Directive? p. 9.

[25] Kennestone Hospital. (1993). Your Right To Decide - A Guide To Advance Directives. Kennestone Hospital Brochure. Item # 18270.

instruct your physician to withhold or withdraw life-sustaining procedures including withdrawal of nutrition and hydration, if you become terminally ill or in situations of a persistent vegetative state.[26]

Although all health maintenance organizations receiving federal reimbursement are mandated by law to provide written and verbal information to each patient regarding advanced directives, the question remains; are all patients equipped with sufficient literacy comprehension skill to fully understand this critical topic?

Statement of the Problem

The topic of advance directives is a critical one, one that all persons should clearly understand. The challenge for healthcare professionals (ie. social workers, nurses, clergy, and physicians) is to provide all individuals with an adequate, understandable explanation of the term advance directives. The discussion of advance directives, a topic most physicians believe demands attention, (80% of physicians in a recent survey expressed a positive attitude toward advance directives)[27] raises concerns that inadequate information given to patients can cause undue fear and confusion.[28] Is the belief of these physicians noteworthy?

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[26] American Journal of Public Health. (1993).

[27] Levin, S. M. Rep. Michigan. (1990). Patient Self-Determination Act of 1990. Congressional Record E 943. 136, No. 39.

[28] Hospital and Health Administration. (1992).

Are patients given adequate, understandable information regarding advance directives? Moreover, does the patient have the cognitive skills to understand written instruction, verbal explanation or even audiovisual instruction? If an individual's cognitive abilities are low, are healthcare professionals able to identify the person's inability to comprehend advance directives?

Twenty-three million American adults may not be able to comprehend information given to them by healthcare professionals.[29] These persons generally function well in their everyday activities; however, the comprehension of healthcare information is difficult at best for these people.[30] Northcutt's national study, Adult Performance Level showed that 19.8 percent of the adult American population, or on out of five lacks the literacy skills needed to effectively function in today's society.[31] A study which tested and surveyed 10,000 people, showed that these adults were unable to effectively use reference documents, catalogs and instruction sheets.[32] Also, some of these people were not aware that the average body temperature is 98.6 Fahrenheit.[33]

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[29] Doak, Doak, Root. (1985). Prepping for Patient Self-Determination Act. Modern Medicine.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Ibid.

Additionally, the economics of health care has changed drastically leaving health care agencies with less staff, time, money and resources to meet the educational needs of their patient population.[34] The consequence of less health care staff requires these agencies to depend more on patient literature to supplement patient education.[35] How effective supplemental literature is should be highly questioned, because 17-21 million Americans cannot read above the sixth-grade level.[36] Several studies have been conducted regarding readability of patient information related to general health.

In a study conducted by Streiff 28 booklets regarding diabetes, contraception, cancer, cardiovascular disease, urinary tract infections, diverticulosis, and exercise were analyzed.[37] The readability scores ranged from grade 6.6 to grade 15.4 with an average of grade 11.2.[38] Another study analyzed 37 cardiac patient education pamphlets using the FOG

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[34] Owen, P., Johnson, E., Frost, C., Porter, K., O'Hare, E. (1993). Reading, Readability, And Patient Education Materials. Cardiovascular Nursing. Vol. 29. No. 2.

[35] Ibid.

[36] National Advisory Council on Adult Education. (1986). Illiteracy in America: Extent, Causes, Suggested Solutions. Washington, DC, Government Printing Office.

[37] Streiff, L.D. (1986). Can Clients Understand Our Instructions? Image Journal Nursing School. Vol. 18. 48-52.

[38] Ibid.

readability formula.[39] Results indicated that the readability of these materials had a mean score of 12.2, with a range of 8.2-17.2 and 38% at or above the college level.[40] A third study analyzed 38 instructional materials regarding information on hypercholesterolemia using both the SMOG and FOG readability formulas.[41] SMOG readability scores indicated a 10.8 grade level and FOG indicated a 10.9 grade level.[42]

Not only do these studies, as well as, others indicate that the educational material given to the general patient population is above the sixth-grade level; we must also take into consideration that not always does the educational level correlate with actual reading ability.[43] Nor, does reading ability always guarantee reading comprehension.[44]

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[39] Owen, P.M., Johnson, E.L., Porter, K.A., Frost, C., O'Hare, E. Slocumb, E.M. (1993). A Determination of the Readability of Cardiac Patient Education Materials. Journal of Cardiopulm Rehabil. Vol. 13.

[40] Owen, P.M., Johnson, E.L., Porter, K.A., Frost, C., O'Hare, E. Slocumb, E.M. (1993). A Determination of the Readability of Cardiac Patient Education Materials. Journal of Cardiopulm Rehabil. Vol. 13

[41] Glantz, K. and Rudd, J. (1990). Readability and Content Analysis of Print Cholesterol Education Materials. Patient Education Counsel. Vol. 16. 109-118.

[42] Ibid.

[43] Meade, C.D., and Byred, J.C. (1989). Patient Literacy and the Readability of Smoking Education Literature. American Journal Public Health. Vol. 79. 204-206.

[44] Owen, P., Johnson, E., Frost, C., Porter, K., O'Hare, E., (1993). Reading, Readability, and Patient Education Materials. Cardiovascular Nursing. Vol. 29, No. 2.

A study using the Wide Range Achievement Test was conducted to determine the relationship between reading ability and reported length of formal education on 87 patients at Norfolk Public Health Service Hospital.[45] Results indicated that 40% of these patients reported having an education of at least 12 years, however; 60% tested at a reading level of seventh to eighth grade. In terms of comprehension, Mohammed wrote five passages regarding general health, each passage was written to have a readability score of fourth, sixth, or eighth grade.[46] Test result yielded that of 20 correct answers, the mean comprehension of 220 patients was 12.4 with 42% scoring less than 10, indicating that subjects understood less than half of what they read.[47]

With this high population of functionally illiterate people living in an advanced technological environment it is necessary to determine whether or not a persons' educational level has an impact on the completion of advance directives. A second consideration to determine is whether those people with a lower educational level are less likely to complete advanced directives and what steps healthcare professionals can take to insure that all patients are adequately informed

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[45] Doak, L.G. and Doak, C.C. (1980). Patient Comprehension Profiles: Recent Finking and Strategies. Patient Counsel Health Education. 3rd Quarter: 101-106.

[46] Mohammed, M. (1964). Patients' Understanding of Written Health Information. Nurs. Res. Vol. 13 100-108.

[47] Ibid.

about their rights regarding medical procedures, including advance directives.

Purpose of the Study

The researcher, as an employee of the hospital has observed a number of patients' medical charts that did not have advance directives that would indicate his/her wishes in the event such directives were needed. Through my observation it appeared that the majority of these patients seemed to be minority, poor, and lacking the cognitive skills necessary to understand advance directives. The purpose of this study is to determine if there is a relationship between a patients' educational level and the completion of advance directives, a living will and/or a durable medical power of attorney. This exploratory study looks at socio-economic variables focusing particularly on an individuals' educational level.

This study takes place in a five hundred bed public hospital where the participants have been admitted due to an acute care need. All participants are medically stable at the time the survey is conducted.

Some studies have shown that uninsured minorities and illiterate persons are at risk for having medical decisions made for them rather than with them.[48] Illiteracy, language barriers, cultural differences often result in people feeling powerless to contend with what is required from the system.

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[48] Hassmiller, S. (1991). Bringing the Patient Self-Determination Act Into Practice. Nursing Management. 22, 29-32.

The social worker employed in the medical setting must be able to identify those persons needing additional support in order that each individual can fully understand their rights as a patient.

It is important to know if there is a relationship between an individuals educational level and the completion of advance directives to insure that all persons regardless of their educational level enjoy the same medical choices. The medical staff in our local hospitals need training in order to identify those person requiring additional support in understanding their rights regarding advance directives. Additionally, hospital personnel need training in how to effectively communicate the purpose and meaning of advance directives.

CHAPTER TWO

REVIEW OF THE LITERATURE

The topic of death and dying have become of particular concern in contemporary health care ethics. Advances in health care have made it possible to greatly extend life, but has also required people to face more difficult health care decisions. Research to date indicates that use of advance directives has widespread approval; however, the rate at which they are actually written is much lower.[49]

It is mandated that competent patients give informed voluntary consent prior to any medical procedure and after the risks and benefits of the procedure has been explained.[50] The right of a competent individual to refuse medical treatment that could save ones' life is based on the ruling of Supreme Court Justice Benjamin Cardozo that "every human being of adult years of sound mind has a right to determine what shall be done with his own body"[51]

When a person who had previously been competent to make his/her own medical decisions becomes incompetent, either a "substituted" or "subjective" judgment may be made by family

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[49] Lynn, J. and Teno J.M. (1993). After the Patient Self-Determination Act: The Need for Empirical Research on Formal Advance Directives. Hastings Center Report. 23, No.1: 20-42.

[50] Nicholson, B. and Matross, G. (1989). Facing Reduced Decision-Making Capacity in Health Care: Methods for Maintaining Client Self-Determination. Social Work. May. 234-238.

[51] Schloendorff v. Society of New York Hospitals, (1914). 211N.Y. 125, 129, 105 N.E. 92.

members and physicians if there is no living will or durable medical power of attorney that exists.[52] In the event the patient has not completed a living will and/or durable medical power of attorney inference is required which has resulted in numerous controversial court cases.

In 1976 the New Jersey Supreme Court case of Karen Ann Quinlan was one such case that illustrates the necessity for explicit, legally binding advance directives. Ms. Quinlan at the age of 21 went into a coma. This comatose state resulted in Ms. Quinlan being placed on a respirator to keep her alive.[53] Her family petitioned the court requesting that she be taken off the respirator and allowed to die.[54] Although family and friends testified that Ms. Quinlan had indicated on several occasions that, "she would not want to be kept alive by such extraordinary means, under any circumstances" the court did not recognize Ms. Quinlan's statements as representing a valid choice.[55]

The case of Earl Spring also illustrates the confusion and controversy that can result in a person not having an advance directive. Mr. Spring, a 78-year-old patient

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[52] Nicholson, B. and Matross, G. (1989). Facing Reduced Decision-Making Capacity in Health Care: Methods for Maintaining Client Self-Determination. Social Work. May. 234-238.

[53] Ibid.

[54] Ibid.

[55] In re Quinlan, (1976). 70 N.J. 10, 335 A. 2d 645.

suffering from senility and requiring kidney dialysis had family members request that he be removed from dialysis.[56] Mr. Springs' wife argued that her husband would "not want to live like this", and "he was an active, decisive man".[57] It could be questioned, however; that an active and decisive individual may in fact want the medical treatment that would prolong their life. Again, lack of written directives establishing Mr. Springs' treatment preferences resulted in family turmoil, and a medical/court dilemma.

In the case of Mr. Brother Fox, at the age of 83 suffered a heart attack and lapsed into a permanent vegetative state.[58] Mr. Fox, like Ms. Quinlan had not prepared a formal advance directive and had stated on previous occasions that he would not want to be kept alive on a respirator if he was in a comatose state.[59] Mr. Fox's guardian also petitioned the court, requesting Mr. Fox be taken off the respirator.[60] Unlike the case of Ms. Quinlan, the request of Mr. Fox's guardian was granted and the right to self-determination was

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[56] Nicholson, B. and Matross, G. (1989). Facing Reduced Decision-Making Capacity in Health Care: Methods for Maintaining Client Self-Determination. Social Work. May. 234-238.

[57] In re Spring. (1980). Mass. App. 405 N.E. 2d 115.

[58] Ibid.

[59] Ibid.

[60] Eichner v. Dillon. (1981). 52 N.Y. 2d 363, 420 N.E. 2d 64.

respected.[61]

The same New Jersey Supreme Court that had heard the case of Ms. Quinlan heard the 1985 case of Claire Conroy.[62] Ms. Conroy suffered from dementia, as well, as a wide range of medical problems. Prior to becoming demented Ms. Conroy neglected to establish an advance directive leaving the court to decide her fate. In this particular court case the court decided that medical treatment can be withdrawn if "the net burdens of the patient's life with treatment clearly and markedly outweigh the benefits that the patient derives from life so that recurring, unavoidable, and severe pain of the patient's life with the treatment would render the life-sustaining treatment inhumane".[63] One of the justices had a difference of opinion, contending that other human values (i.e. independence, privacy, dignity), are outweighed when pain is the only source for the determination of best interest.[64] This same court noted that it had erred in "disregarding evidence of statements that Ms. Quinlan made to

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[61] Ibid.

[62] Nicholson, B. and Matross, G. (1989). Facing Reduced Decision-Making Capacity in Health Care: Methods for Maintaining Client Self-Determination. Social Work. May. 234-238.

[63] In re Conroy. (1985). 98 N.J. 320, 393-394, 486 A. 2d 1209.

[64] Nicholson, B. and Matross, G. (1989). Facing Reduced Decision-Making Capacity in Health Care: Methods for Maintaining Client Self-Determination. Social Work. May. 234-238.

friends concerning artificial prolongation of lives of those who were terminally ill."[65]

After much debate the court granted Ms. Quinlan's father the authority to exercise her right to refuse medical treatment.[66] The Quinlan ruling established that an individual's constitutional right to privacy would encompass the right to withhold life-sustaining treatments.[67] This right was further endorsed by the U.S. Supreme Court in the 1990 Nancy Cruzan vs. Director, Missouri Department of Health case.[68] The Cruzan case additionally established, as part of the "liberty" guaranteed by the Fourteenth Amendment, to the discontinuance of life-sustaining treatment.[69] Although all of the Justices agreed to the right of the discontinuance of life-sustaining treatment, not all agree on how specific individuals must be in making their treatment wishes know.[70]

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[65] In re Conroy. (1985). 98 N.J. 320, 393-394, 486 A. 2d 1209.

[66] Emanuel, E. and Emanuel, L. (1992). Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis. JAMA. Vol. 267, No. 15.

[67] Ibid.

[68] White, B.D., Siegler, M., Singer, P., Iserson, K. (1991). What Does Crezan Mean to the Practicing Physician? Arch Inter Med. 151: 925-8.

[69] Emanuel, E.J. and Emanuel, L.L. (1992). Proxy Decision Making For Incompetent Patients: An Ethical and Empirical Analysis. JAMA. Vol. 267, No. 15.

[70] Silverman, H.J., Vinicky, J.K., Gasner, M.R. (1992). Advance Directives: Implications for Critical Care. Critical Care Medicine. Vol. 20, No. 3.

This decision by the Supreme Court suggested that persons with living wills and durable power of attorney for health care would allow substantial proof that would be constitutionally enforceable.[71] Passage of the Patient Self-Determination Act of 1990 gave further recognition to the use of advance directives.[72] This act requires all health care facilities receiving government insurance money (i.e. medicare, medicaid) to provide individuals with written information regarding their rights under state law to make decisions about medical care including the right to accept or refuse medical treatment.[73]

"Natural death" or "living will" acts have been enacted in forty-one states and the District of Columbia allowing competent patients to prepare statements concerning the extent of life-sustaining treatments they wish to receive.[74] Durable power of attorney for health care statutes that enable agents to withdraw or withhold life support are present in twenty-seven states.[75] The enactment of these laws have afforded individuals the opportunity in advance to clearly state what,

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[71] Emanuel, E.J. and Emanuel, L.L. (1992). Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis. JAMA. Vol. 267, No. 15.

[72] Silverman, H.J., Vinicky, J.K., Gasner, M.R. (1992). Advance Directives: Implications for Critical Care. Critical Care Medicine. Vol. 20, No. 3.

[73] Ibid.

[74] Ibid.

[75] Ibid.

if any, medical treatments are desired in the event the person is unable to communicate their wishes.

One of America's strongest pillars that has been built and embraced is that of diversity of values. Diversity in values result in diversity of decisions. How one individual measures what is in the best interest of a patient can be measured quite differently by another person. It is the belief of some that being relieved from pain is of the utmost importance, while others believe in the preservation of life regardless of the patients state of being.[76] Still another perspective supports the belief that treatment is not necessary if the patient has lost the ability for autonomous living.[77]

The cases presented, as well as, the various perspectives discussed illustrates the difficulty and complexity involved in decision making for another individual. This lack of information available when a decision must be made requires another person's values and beliefs be placed on the patient. Despite the usefulness, availability, ethical and legal recognition, of advance directives, only 9% to 18% of the

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[76] Nicholson, B. and Matross, G. (1989). Facing Reduced Decision-Making Capacity in Health Care: Methods for Maintaining Client Self-Determination. Social Work. May. 234-238.

[77] Emanuel, E.J. (1987). A Communal Vision of Care for Incompetent Patients. Hastings Center Report. 17(5), 15-20.

population have completed the necessary documents.[78] Several reasons have been cited for the low rate in the use of advance directives, living will and power of attorney for health care. One possible reason is the universal reluctance in discussing issues regarding death and dying. Although this is indeed a possibility recent studies indicate that most patients prefer to understand their illness and would like these discussions to occur.[79] Patients, however; felt that it was the physicians responsibility to initiate these discussions rather than themselves.[80] Although research indicates physicians herald the idea of advance directives most have a difficult time with such discussions and indicate uncomfortable feelings in this area.[81] Numerous empirical studies indicate that little discussion between patient and physician regarding the use and withdrawal of life-sustaining medical has occurred.[82] Possibly these uncomfortable feelings physicians have with discussing death and dying are due to the fact that most physicians have dedicated their lives and skills to the prevention of illness and the preservation of life. Other

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[78] Ibid.

[79] Barriers to Completion of Living Wills. (1992). American Academy of Family Physicians. V. 46, p. 1529.

[80] Ibid.

[81] Ibid.

[82] Emanuel, L., Barry, M., Stoeclke, J. Ettelson, L., Emanuel, E. (1991). Advance Directives for Medical Care- A Case for Greater Use. New England Journal of Medicine. 324: 889-895.

reasons indicated for the low usage rate of advance directives and durable power of attorney for health care is lack of information and lack of encouragement from health care professionals and families.[83] A study that reviewed 3,058 medical records found that the topic of advance directives was mentioned in only 70 records or 23 percent.[84]

In 1988, a public opinion survey by the American Medical Association was conducted. In this survey it was found that 56% of the general population had communicated with their family members what actual treatment procedures they preferred in the event they suffered from a coma; however, of this 56% only 15% had actually completed advance directives.[85] Emanuel and colleagues reported in their article, Advance Directives for Health Care that greater than 90% of respondents had a positive attitude regarding advance directives but less than one in ten persons had completed the necessary documents. Greg Sachs and colleagues reported that from a randomized controlled trial of an educational

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[83] High, D.M. (1993). Advance Directives and the Elderly: A Study of Intervention Strategies to Increase Use. The Gerontologist. Vol. 33, No. 3, 342-349.

[84] Teno, J.M., Lynn, J., Phillips, R., Murphy, D., Youngner, S., Bellamy, B., Connors, A., Desbiens, N., Fulkerson, W., Knaus, W. (1994). Do Formal Advance Directives Affect Resuscitation Decisions And the Use of Resources for Seriously Ill Patients? The journal of Clinical Ethics. Vol. 5 No.1.

[85] Lynn, J. and Teno, J. (1993). After the Patient Self-Determination Act: The Need for Empirical Research on Formal Advance Directives. Hasting Report. 20-23.

intervention that a majority of patients (85%) did not implement a living will. A contrast was found in a study conducted by Lawrence Markson and Knight Steel that over 50% of homebound patients who were counseled on the use of advance directives completed the necessary paperwork. The assumption underlying the Patient Self-Determination Act of 1990 was that given adequate information and encouragement regarding advance directives patients would use them.[86] As discussed earlier all health care facilities (i.e. hospitals, nursing homes, hospice programs, and home health agencies) are mandated under federal law to provide written information on advance directives to each of their patients and document that this policy has been followed. Although health care facilities report great compliance with this regulation, studies consistently reflect a low rate of usage.[87] One persistent concern noted by Lynn and Teno is whether the meaning and usefulness might be linked to a "middle class" approach to health care. The very idea of offering advance directive information to patients might be altered when persons are too poor or too uneducated demand health care at all.

Recently, two studies attempted educational interventions in a general medical outpatient clinic and a geriatrics

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[86] LaPuma, J., Orentlicker, D., Moss, R.J. (1991). Advance Directives on Admission: Clinical Implication and Analysis of the Patient Self-Determination Act of 1990. Journal of the American Medical Association. 266, 402-405.

[87] Barriers to Completion of Living Wills. (1992). American Academy of Family Physicians. V. 46, p. 1529.

outpatient clinic. Each produced a 15% increase in the use of advance directives verses intensive interventions.[88] Another study was conducted during 1991 in Lexington - Fayette County, Kentucky. This area was identified as one of five places in the United States closest to the overall American demographics as indicated by the 1990 census.[89] In this study a sample size of 293 persons, age 65 to 93 were separated into six different groups by a random draw.[90] Seventy-one percent were female, 84% were white, 34% were married, 52% widowed, and 14% divorced, separated or never married.[91] Sixty one percent believed their health to be either excellent or good, while the remaining 39% reported their health was either fair or poor.[92] Thirty-one percent had less than a high school education, 25% had attended college, and 23% had completed college or both college and graduate work.[93] Yearly income levels reported were 46% had $10,000 or less, 18% had an income of over $10,000, but less than 20,000, 20% from $20,000

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[88] Hare, J., and Nelson, C. (1991). Will Outpatients Complete Living Wills? A Comparison of Two Interventions. Journal of General Internal Medicine. 6, 41-46.

[89] Waldrop, J. (1992). All-American Markets. American Demographics. 14, 24-30.

[90] High, D.M. (1993). Advance Directives and the Elderly: A Study of Intervention Strategies to Increase Use. The Gerontologist. Vol. 33, No. 3, 342-349.

[91] Ibid.

[92] Ibid.

[93] Ibid.

to $40,000, and 16% had over $40,000.[94] Additionally, reports indicated that sixty percent lived alone, 84% had living children, and 72% had living siblings.[95] Data from this study indicated an increase in use by each group following the intervention strategy; however, the moderate materials plus meeting (participants who received a moderate amount of written material and attended meetings) indicated the only statistically significant increase.[96] The reasons cited for not completing advance directives 50% and 49%, respectively) was deferring to others and putting it off, (20% and 11%, respectively) difficulty in arranging execution of the documents, relying on others to handle arrangements as needed accounted for 24% and still others (12% and 16%, respectively) reported "it was to early to plan for that sort of thing" or "don't want to think about such things".[97]

Noted in this study was that the level of education, race, and income was related to the completion of advance directives. Those persons with less than a high school education had a completion rate of 21%, while those with high school had a completion rate of 34%.[98] Following with the

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[94] Ibid.

[95] High, D.M. (1993). Advance Directives and the Elderly: A Study of Intervention Strategies to Increase Use. The Gerontologist Vol. 33, No., 342-349.

[96] Ibid.

[97] Ibid.

[98] Ibid.

highest completion rate (50%) were those with a college education.[99] Race also was associated with completion rate 85% white compared to 62% black).[100] Participants having a higher income level ($20,000 or more) also had a greater completion rate; however, this was not a statistically significant association.[101]

Another study that was completed was a telephone survey questionnaire that was administered to patients who were hospitalized before and after the implementation of the Patient Self-Determination Act of 1990. This survey indicated that there was a positive relationship between the completion of advance directives and the patients race (white), income (greater than or equal to $10,000), and the level of education (high school or more).[102] Also indicated was a significantly higher number of patients hospitalized after the implementation of the Patient Self-Determination Act had greater knowledge of advance directives than those hospitalized prior to the act.[103] Although a greater number of patients had knowledge of these directives few obtained and

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[99] Ibid.

[100] High, D.M. (1993). Advance Directives and the Elderly: A Study of Intervention Strategies to Increase Use. The Gerontologist Vol. 33, No. 3, 342-349.

[101] Ibid.

[102] Appleton and Lange (1993). Journal Family Practice. 37, 363-369.

[103] Ibid.

completed the necessary documents.[104]

Further study by the University Medical Center in Jacksonville, Florida was conducted to evaluate the effect of the implementation of the Patient Self-Determination Act. This study like the above postulated that patients hospitalized after the implementation of PSDA would be more likely to complete advance directives than those who had been hospitalized prior to the implementation of PSDA.[105] This study also hypothesized that attitudes and behaviors may be related to patient demographic features.[106] Like the previous study it was found that those patients admitted to an acute care facility after the implementation of PSDA were more likely to have knowledge regarding advance directives; however, this new knowledge did not significantly increase the actual obtaining of advance directives.[107] Further, this study indicated the knowledge of advance directives is significantly related to the participants race, income, and level of education both in the pre and post PSDA samples.[108] Still another study included 214 participants ages 65 to 90 years. Participants at ten various nutrition sites for senior

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[104] Ibid.

[105] Appleton and Lange (1993). Journal Family Practice. 37, 363-369.

[106] Ibid.

[107] Ibid.

[108] Ibid.

citizens were given a questionnaire to complete with assistance as needed. Data indicated that 15% of those surveyed already had advance directives.[109] Of those participants who did not have advance directives 96% indicated they wanted to complete the needed documents in the future.[110] Two characteristics were found that separated the subjects who had completed the advance directives from those who had not. Participants who were highly educated were more likely to have completed advance directives than those who were less educated.[111] Subjects reported that the needed documents were too long and felt they needed assistance in completing these documents.[112] The author recommended that additional information and assistance be made available in an effort for those who wish to complete advance directives be able to do so.

Lastly, a study was conducted where seventy-five subjects ages 60 to 90 were given a questionnaire to see if they were familiar with their state laws regarding advance directives, 52% indicated they were.[113] Of these subjects 81% said they would like to discuss advance directives with their

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[109] Barriers to Completion of Living Wills. (1992). American Academy of Family Physicians. V. 46, p.1529.

[110] Ibid.

[111] Ibid.

[112] Ibid.

[113] Ibid.

physicians, 11% indicated had discussed end-of-life care with their physician and 3% had discussed a living will.[114] None of the participants had completed the necessary paperwork.[115] The author believed that this reluctance to sign the needed documents is possibly due to lack of knowledge about advance directives, lack of communication from physicians regarding advance directives and a preference for proxy decisions.[116]

As noted throughout the literature review many studies indicate that lack of knowledge, education, race and income level play an important role in the completion of advance directives. Additionally, this review indicates that with educational interventions and support, an increase in the completion of advance directives is seen. The social worker in various settings (i.e. hospitals, nursing homes, adult day programs, senior citizens sites) through various assessment methods can play an important role in identifying those persons needing additional support. The social worker can also assist the patient in the understanding of advance directives in an effort to allow each patient (regardless of educational level, race or income) to maintain control over his/her treatment desires. Lastly, the social worker must assist the patient's family, and staff members in developing

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[114] Barriers to Completion of Living Wills. (1992). American Academy of Family Physicans. Vol. 46, p. 1529.

[115] Ibid.

[116] Barriers to Completion of Living Wills. (1992). American Academy of Family Physicians. Vol. 46, p. 1529.

positive communication in this critical area of life.

Operational Definitions

The patient is defined as that individual who has been admitted to an acute care setting for medical care and treatment. Advance directives are documents (i.e. living will, durable power of attorney) that have been completed in advance of an illness which identifies the patient's choices regarding medical treatment if the patient should become unable to make decisions. Educational level is defined as the level that one has attained in their knowledge and development resulting from a formal educational process.

Statement of Hypotheses

The null hypotheses in this study is: There is no significant relationship between a patient's educational level and the competition of advanced directives.

CHAPTER THREE

METHODOLOGY

Research Design

The research design used in this study is an exploratory research design aimed at determining if there is a relationship between a patient's educational level and the completion of advance directives.

In an exploratory research design little is known about the particular area being studied and no sound theories have been proposed. This researcher utilizes the exploratory research design in an effort to explore whether there is a relationship between a patients educational level and the completion of advance directives. This design does not produce statistically sound data; it does not intend to. It simply uncovers general ideas about the topic and lays the ground work or builds a foundation for further research to be explored.

It is this researcher's hope that this study may build a foundation of tentative theories that can later be researched with more precise and complex research designs offering more conclusive results.

Sampling

The sampling technique used in this study is the convenience or availability sampling. This sampling was chosen because it is a non-probability sampling technique that uses the most available subjects to constitute the sample. This technique is less expensive than other techniques, is convenient and utilizes the most accessible sampling units where the needed population is located.

Each of the participants were identified as patients in an acute care setting of a hospital. A patient census was obtained, patient medical charts were reviewed, and floor registered nurses were questioned to insure that the patient was medically stable and able to answer survey question. A total of fifty patients were identified. Once a sample of the population was chosen, those chosen were administered a questionnaire of socioeconomic questions. No specific efforts were be made to ensure representation based on age, income, race, or medical treatment.

Research Setting

Kennestone Hospital, a member of the Northwest Georgia Health System, five hundred bed public hospital, located in Marietta,Georgia will be used as the setting for this research. Permission for this research will be obtained from the Director of Social Services to review charts and administer the questionnaire to the selected group.

In 1993, the system received 93.8 percent of its admissions from seven counties, which comprised its primary service area. Within these seven counties, the system's market share of total admissions were: Paulding (67.7%), Cobb (58.1%), Cherokee (58.0%), Douglas (48.9%), Pickens (44.8%), Bartow (16.8%), and Carroll (5.6%) (Marketing and Planning, 1993). It is estimated that in five years, 1998 the Atlanta area population will increase by 12.6 percent, reaching nearly 3.5 million (Marketing and Planning, 1993).

The counties with the highest projected growth in the greater Atlanta area are: Fayette (26.9%), Gwinnett (22.1%), Paulding (20.5%), Cherokee (19.9%), and Henry (19.8%) (Marketing and Planning, 1993).

The most rapidly growing age group in the primary service is the 45-64 year old group, projected to increase by 29.3 percent, followed by the 75 + age group, to increase by 18.2 percent (Marketing and Planning, 1993).

From this research setting the selected group was

randomly chosen. Upon admission to this hospital each patient is given information on advance directives and encouraged to complete the necessary paperwork. In reviewing the medical record and administering the questionnaire this study attempted to identify if there is a relationship between educational level and the completion of advance directives.

Instrumentation

The instrument used for this research was developed by the researcher and contained twelve questions. The questionnaire collect information regarding each patient's socioeconomic status in an effort to identify the patient's educational level.

The ordinal level of measurement was used in an effort to rank the order of each patient's educational level (i.e. low, moderate, high). This type of rank value measurement indicates whether the patient has more education than another patient. Ordinal measurement does not indicate absolute quantities and there is no assumption of equal intervals between the various ranks.

Some questions from a research study conducted in 1991 in Lexington-Fayette County, Kentucky was also used in the study. High reported that in the Kentucky study a total of 431 participants were recruited from eight different senior congregate housing units (n=177), from a volunteer research pool at the Sanders-Brown Center on Aging, University of Kentucky (n=221), and from two geriatrics outpatient clinics at the University of Kentucky Medical Center (n=33).

Two groups were included: a control group and an

intervention group. The control group received only a letter explaining the study and were included in the follow-up interview. The intervention group received one of three types of printed materials and an invitation was given to half of the intervention participants to attend a free counseling regarding advance directives, as well as, legal assistance to complete an advance directive. The intervention group was also included in the follow-up telephone interview.

Overall, it was designed to give the researcher an idea of the relationship (if any) between the independent variable of educational level and the dependent variable of completion of advance directives.

Data Analysis

A patient census was obtained, patient charts reviewed and floor registered nurses were questioned to insure that patients were medically stable and able to answer survey questions. Once the patient was identified each was given a questionnaire. The questionnaire was then reviewed to identify the educational level of each patient. Simple descriptive statistics was used to describe the data from the overall responses. The statistics described are percentages and frequencies of educational level (low, moderate, high) and the percentages and frequencies of advance directives completed and advance directives not completed.

Table 1. Frequency distribution of age (N=50)

Variables	Frequency	Percent
Age		
25-35	1	2.0
36-46	3	6.0
46-55	8	16.0
56-65	8	16.0
66-75	18	36.0
76-Plus	12	24.0
Total	50	100.0

Table 2. Frequency distribution of males and females (N=50)

Variables	Frequency	Percent
Gender		
Female	23	46.0
Male	27	54.0
Total	50	100.0

Table 3. Frequency distribution of marital status (N=50)

Variables	Frequency	Percent
Marital Status		
Single	2	4.0
Married	27	54.0
Divorced	10	20.0
Widow	11	22.0
Total	50	100.0

Table 4. Frequency distribution of religion (N=50)

Variables	Frequency	Percent
Religion		
Protestant	41	82.0
Catholic	4	8.0
Jewish	1	2.0
Other	4	8.0
Total	50	100.0

Table 5. Frequency distribution of race (N=50)

Variables	Frequency	Percent
Race		
Caucasian	43	86.0
African American	6	12.0
Hispanic	1	2.0
Total	50	100.0

Table 6. Frequency distribution of educational level (N=50)

Variables	Frequency	Percent
Educational Level		
0-7	13	26.0
8-12	20	40.0
12-Plus	10	20.0
Technical	2	4.0
BA or BS	1	2.0
MA or MS	3	6.0
PHD	1	2.0
Total	50	100.0

Table 7. Frequency distribution of children < 18 yrs (N=50)

Variable	Frequency	Percent
Child <18yrs		
Yes	3	6.0
No	47	94.0
Total	50	100.0

Table 8. Frequency distribution of children any (N=50)

Variable	Frequency	Percent
Child Any		
Yes	44	88.0
No	6	12.0
Total	50	100.0

Table 9. Frequency distribution of income (N=50)

Variable	Frequency	Percent
Income		
Less 15K	12	24.0
16-25K	15	30.0
26-35K	9	18.0
36-45K	5	10.0
46-55K	4	8.0
56-65K	3	6.0
66-75K	1	2.0
76-85K	1	2.0
Total	50	100.0

Table 10. Frequency distribution of health (N=50)

Variables	Frequency	Percent
Health		
Excel	4	8.0
Good	20	40.0
Fair	12	24.0
Poor	14	28.0
Total	50	100.0

Table 11. Frequency distribution of know advance directives (N=50)

Variables	Frequency	Percent
Know Advance Directives		
Yes	42	84.0
No	8	16.0
Total	50	100.0

Table 12. Frequency distribution of advance directives completed (N=50)

Variables	Frequency	Percent
Advance Directives Completed		
Yes	17	34.0
No	33	66.0
Total	50	100.0

In Table 1 through 12 the demographic characteristics shows 1 (2%) of the respondents were age 25-35, 3 (6%) were 36-46, 8 (16%) fell into the age groups of 46-55 and 56-65. The majority of respondents 18 (36%) were 66-75 and 12 (24%) were age 76-plus.

The table further indicates that 23 (46%) were female and 27 (54%) were male. Marital status showed that 2 (4%) were single, 27 (54%) were married, 10 (20%) were divorced, and 11 (22%) were widow. In the area of religion, Protestant was the majority, 41 (82%), Catholic 4 (8%), Jewish 1 (2%), and 4 (8%) indicating other. Race showed caucasian 43 (86%), African American 6 (12%), and Hispanic 1 (2%).

Additionally, the table indicates that 13 (26%) had an educational level of 0-7, 20 (40%) had an educational level of 8-12, 10 (20%) had 12-plus, 2 (4%) reported a technical degree, 1 (2%) reported a four year college degree, 3 (6%) reported masters level degree, and 1 (2%) reported a doctorate degree. Data regarding if the patient had children under the age of eighteen year indicates that 3 (6%) do, and that 47 (94%) do not. The data does however indicate that the majority of participants 44 (88%) do have children, with 6 (12%) indicating no children.

Patient characteristics further indicate that 12 (24%) had an income of less than 15K, 15 (30%) had an income of 16-25K, 9 (18%) had an income of 26-35K, 5 (10%) had an income of 36-45K, 4 (8%) had an income of 46-55K, 3 (6%) had an income

of 56-65K, 1 (2%) had an income of 66-75K, and 1 (2%) had an income of 76-85K. Data regarding how patients believe their health to be indicates 4 (8%) believe it to be excellent, 20 (40%) believe it to be good, 12 (24%) believe it to be fair, and 14 (28%) believe it to be poor.

In the area of patient knowledge regarding advance directives, the majority 42 (84%) indicate they are familiar with advance directives, and 8 (16%) indicate they are not familiar with advance directives. Although the majority of patients report they are familiar with advance directives the data indicates 33 (66%) have not completed an advance directive, and 17 (34%) report they have completed such directives.

Table 13. Cross Tabbing Patient Demographic Characteristic, Educational Level with Advance Directives Completed.

Variables	Frequency	Percent
0-7	13	26.0
8-12	20	40.0
12-Plus	10	20.0
Technical	2	4.0
BA or BS	1	2.0
MA or MS	3	6.0
PHD	1	2.0
Total	50	100.0

In table 13 educational level 0-7 indicates that 2 (4%)

had completed advance directives and 11 (22%) had not. Educational level 8-12 shows that 7 (14%) had completed a directive and 13 (26%) had not. Respondents with 12-plus level of educational indicated that 4 (8%) had completed an advance directive and 6 (12%) had not. Those with a technical level of education showed that 2 (2%) had completed an advance directive and 0 (0%) had not. BA or BS educational level indicated that 0 (0%) had completed advance directives and 1 (2%) had not. Respondents having a MA or MS level of education showed that 1 (2%) had completed an advance directive and 2 (4%) had not. PHD respondents indicated 1 (2%) had completed advance directives and 0 (0%) had not.

Table 14. Single Sample Chi-Square Test

Group	Value	Degree of Freedom	Significance
Education	14.41126	5	.01320

In table 14, the chi-square indicates the following:

1. Five degrees of freedom show chi-square = 14.41126 for the hypothesis and the significance of .01320.

Given the alpha level of .05 a conclusion can be drawn that the null hypothesis is accepted and there is no significant relationship between a patient's educational level and the completion of advance directives.

CHAPTER FIVE

SUMMARY AND CONCLUSION

In summary, findings from this study include a description of patient demographic characteristics and results of the impact of patients educational level on the completion of advance directives. The research accepts the hypotheses in the study. The results indicate there is no significant relationship between a patient's educational level and the completion of advance directives.

Participant characteristics were similar in regard to age, marital status, religion, race, children under eighteen years of age, having children, educational level gender, familiar with advance directives and the completion of advance directives. The majority,(66%) were over the age of 65, which was not surprising due to the study taking place in an acute care setting where the majority of the population most often consists of an older population. The majority, (54%) of the participants were married and had 12 years or less education, (66%). Although this study does not indicate a relationship between a patients educational level and the completion of advance directives it does support the findings of previous researchers who demonstrated that most patient printed education materials are beyond the reading ability of the majority of patients. A high percentage, (82%) were of the protestant faith and also caucasian,(86%). This high percentage of protestant and caucasian participants was not

surprising due to the geographic location of the study. The majority, (94 %) did not have children under the age of eighteen years of age which again was not surprising due the average age of the population. Eighty-eight reported they did have children. The majority, (84%) of the participants indicated they were familiar with advance directives; however, the term advance directive had to be explained to most of them using the terms living will and/or medical durable power of attorney, most understanding the term living will. Also many participants stated they had "heard something about this along with a lot of other stuff" given to them at the time of admission. Other information given to patient at time of admission include consent to be treated, financial responsibility forms, etc. Lastly, the majority, (66%) had not completed the necessary documents.

Although the study results indicate that the majority of the participants are aware of advance directives there is failure in acting upon this awareness. This raises the question, is admission to a hospital the appropriate time to give people information regarding advance directives? As reported by Appleton and Lange in a study conducted at University Medical Center in Jacksonville, Florida it may be unrealistic to expect all patients to understand or even to recall one specific document in such a setting.

Additionally, when admitted to an acute care setting generally the person is in acute pain which would limit their

understanding of materials received. Another question that arises is whether the person giving the information clearly understands it and is able to clearly communicate to the patient the necessary information. It is one thing to say one is familiar with a particular topic and another thing to actually understand the topic in order that one may benefit from it.

It is important that we understand why people do and do not write advance directives, especially when study results indicate that the majority are familiar with this topic. If the majority of people do not write advance directives is it because they may not want to have responsibility for these choices? If this is a possibility than one might question the current policy and practice and the need for reshaping it. Much research on the issue of advance directives is needed before any further substantial social resources is committed to a policy/practice that may well be in need of a new strategy.

Limitations of the Study

This study had two methodological limitations. First, questions not available on the questionnaire may have limited some other significant data; specifically information about individual belief systems regarding the sanctity of life, death, assisted suicide, suicide, abortion,etc. Also questions regarding what motivates or what

are the incentives for a patient to complete the necessary documents. These questions could give more information regarding what affects the completion of advance directives.

Second, the study was limited to the sample using only one hospital in the metropolitan Atlanta area. Therefore, it can not be assumed that the selected participants in this study are representative of all possible participants in similar settings.

Suggested Research Directions

As indicated earlier questions regarding a person's belief system not available on the questionnaire may have limited specific information in answering the question, what impacts the completion of advance directions. These questions should be researched in an effort to better understand the implications of such questions. Also research variables (i.e. age, years of education) should be made continuous, rather than grouped. Additionally, research should address the current policy and practice in place to determine if other strategies regarding self-determination would be more optimal. For example, giving patient information regarding advance directives during hospital discharge teaching or giving patients this information in a physicians office setting.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

It is felt by this researcher that further exploration regarding advance directives could contribute more complete knowledge in the field of medical social work practice.

The Social Work Code of Ethics states that "the social worker should make every effort to foster maximum self-determination on the part of their clients." It is than the responsibility of social workers to facilitate client understanding of specific medical treatments, the consequences of those medical interventions, and the various advance directives that will allow for self-determination.
Social workers should have a clear understanding of the various forms of advance directives so that they are able to provide patients the education and counseling necessary to maximize self-determination and personal autonomy.

According to Sansone and Phillips (1995), the involvement of a social work professional could facilitate open communication, a task that no other profession is better equipped to accomplish. Additionally, according to Germain (1984), engaging patients to participate in a more active role in the treatment and management of illness and disability, prompting or advocating that the organization be responsive to the need for self-determination, and obtaining information regarding the individual's present and future needs are all

tasks of the a social work professional.

The social work profession as a whole should also work to influence and create policy changes in order enhance patient self-directedness. Finally, social workers should be integral members of quality assurance committees and ethics committees.

Appendix A

DIRECTIONS: Please indicate your response by placing an X for each question.

1. How old are you?

   _____ 25 - 35

   _____ 36 - 45

   _____ 46 - 55

   _____ 56 - 65

   _____ 66 - 75

   _____ 76 - over

2. Your sex:

   _____ Female

   _____ Male

3. Marital status:

   _____ Single

   _____ Married

   _____ Divorced

   _____ Widow/widower

4. What is your religion?

   _____ Protestant

   _____ Catholic

   _____ Jewish

   _____ Other

5. What is your race?

_____ Caucasian

_____ African American

_____ Asian

_____ Hispanic

_____ Other

6. What is the highest educational level that you completed?

_____ Grade School

_____ High School

_____ Some College

_____ Technical Degree

_____ Baccalaureate Degree

_____ Masters Degree

_____ Doctoral Degree

_____ Other

7. Do you have children under the age of 18 years?

_____ Yes

_____ No

8. Do you have children?

_____ Yes

_____ No

9. What is your annual family income?

_____ Less than 15,000

_____ 16,000 - 25,000

_____ 26,000 - 35,000

_____ 36,000 - 45,000

_____ 46,000 - 55,000

_____ 56,000 - 65,000

_____ 66,000 - 75,000

_____ 76,000 - 85,000

_____ 86,000 - 95,000

_____ 96,000 - 100,000

_____ 100,000 - Over

10. Do you believe your health to be:

_____ Excellent

_____ Good

_____ Fair

_____ Poor

11. Are you familar with Advance Directives (Living Will and/or Durable Medical Power of Attorney

_____ Yes

_____ No

12. Have you completed an Advance Directive/Living Will?

_____ Yes

_____ No

Appendix B

Dear Patient:

I am an employee of Kennestone Hospital and am working on my graduate degree at Clark Atlanta University School of Social Work. I am presently seeking participants to assist me in completing a questionnaire.

I have talked with Promina Kennestone Hospital management and they are willing to support me in this project and have given me permission to administer the questionnaire.

This is not a test. There are no right or wrong answers. I will be available if there are any questions or concerns. Your answers will be held in the strictest of confidence.

I would like to thank you in advance for assisting me in this study. Results of the study will be available upon request.

Sincerely,

Lisa R. Kroger
MSW Student

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